

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3363ALZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/23/2011
NAME OF PROVIDER OR SUPPLIER SPRING VALLEY ALZ CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6428 CRYSTAL DEW LAS VEGAS, NV 89118		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a annual State Licensure survey conducted at Special Loving Care Alzheimer's Center from 2/8/11 to 3/23/11. It was determined this facility had been cooking meals and delivering them to other facility. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The following deficiency were identified:	Y 000		
Y 257 SS=F	449.217(7) Inspections-Approved by BHPS NAC 449.217 7. The equipment used for cooking and storing food and for washing dishes in a residential facility with more than 10 residents must be inspected and approved by the Bureau of Health Protection Services of the Division and the state and local fire safety authorities. This Regulation is not met as evidenced by: Based on interview with the facility owner on 2/8/11, the facility failed to have adequate facilities and equipment for the preparation and service of food for more than 10 residents. Findings include: An on-site visit was conducted at Special Loving	Y 257		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 257	Continued From page 1 Care Alzheimer's Center (SLCAC) on 2/8/11. The facility owner reported she operated SLCAC and this facility which is licensed for 10 beds. The owner reported her staff was preparing meals for the residents of this facility and the residents at SLCAC at this facility. Meals were then transported to SLCAC. The facility does not meet the requirements of NAC 446 and does not have a permit to prepare meals for more than 10 residents Severity: 2 Scope: 3	Y 257			

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